

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH County <u>Garnett</u>		17647
Village or City <u>Barton</u> (No.)		(S)
<sup>2</sup> FULL NAME <u>Bittinger</u>		
PERSONAL AND STATISTICAL PARTICULARS		
<sup>3</sup> SEX <u>F</u>	<sup>4</sup> COLOR OR RACE <u>W</u>	<sup>5</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>C</u>
<sup>6</sup> DATE OF BIRTH <u>Oct 9</u> (Month) (Day) <u>1916</u> (Year)		
<sup>7</sup> AGE ..... yrs. .... mos. <u>0</u> ds. OR min. ?	IT LESS than 1 day, .... hrs.	
<sup>8</sup> OCCUPATION (a) Trade, profession, or particular kind of work <u>C</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>C</u>		
<sup>9</sup> BIRTHPLACE (State or country) <u>Garnett Co. Mo</u>		
<sup>10</sup> NAME OF FATHER <u>Harrison Bittinger</u>	<sup>11</sup> BIRTHPLACE OF FATHER (State or country) <u>Garnett Co</u>	
<sup>12</sup> MAIDEN NAME OF MOTHER <u>Nellie Bowman</u>	<sup>13</sup> BIRTHPLACE OF MOTHER (State or country) <u>Garnett Co</u>	
<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Harrison Bittinger</u> (Address) <u>Barton Md</u>		
<sup>15</sup> Filed <u>Oct 11</u> , 1915	<sup>16</sup> PLACE OF BIRTH OR REMOVAL <u>160 Washington</u>	<sup>17</sup> DATE OF BURIAL <u>Oct 11</u> , 1915

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 163

St. \_\_\_\_\_ Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

MEDICAL CERTIFICATE OF DEATH		
<sup>16</sup> DATE OF DEATH <u>Oct 9</u> (Month) (Day) <u>1915</u> (Year)	<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from 191..., to 191..., 191... that I last saw h... alive on ..., 191... and that death occurred on the date stated above, at ..., 191... The CAUSE OF DEATH* was as follows:	
<u>Still birth</u>		
(Duration) yrs. mos. ds.		
Contributory Secondary		
(Duration) yrs. mos. ds.		
(Signed) <u>S. A. Boncher</u> M. D. , 191... (Address) <u>Barton Md</u>		
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.		
<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds.		
Where was disease contracted, If not at place of death?		
Former or usual residence.		
<sup>19</sup> PLACE OF BURIAL REMOVAL <u>160 Washington</u>		
<sup>20</sup> UNDERTAKER <u>No undertaker</u>		
ADDRESS		

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age.

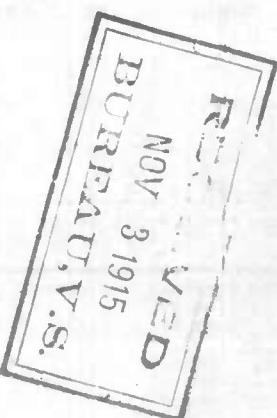
For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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<sup>1</sup> PLACE OF DEATH  
County Garrett

17648  
74

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 166

Village or City Oakland (No.)

Water St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

<sup>2</sup>FULL NAME Mardon Clark Powers

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX Male <sup>4</sup> COLOR OR RACE white <sup>5</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

<sup>6</sup> DATE OF BIRTH Feb. 13, 1886  
(Month) (Day) (Year)

<sup>7</sup> AGE 29 yrs. 9 mos. 18 ds. If LESS than 1 day.....hrs.  
OR.....min.?

<sup>8</sup> OCCUPATION 1910 Mail Carrier  
(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

<sup>9</sup> BIRTHPLACE Maryland  
(State or country)

<sup>10</sup> NAME OF FATHER John Powers

<sup>11</sup> BIRTHPLACE OF FATHER Maryland  
(State or country)

<sup>12</sup> MAIDEN NAME OF MOTHER Martha Sigler

<sup>13</sup> BIRTHPLACE OF MOTHER Maryland  
(State or country)

<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mardon C. Powers

(Address) Dowland Md.

15 Filed Nov. 1st, 1915 M. White  
S.R. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH Oct 31, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from 1914, 1915 to Oct 31, 1915,

that I last saw him alive on Oct 31, 1915

and that death occurred on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH\* was as follows:

Cerebral Tumor

(Duration) 1 yrs. 6 mos. 0 ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) M. J. Broadwater, M. D.  
Nov. 1, 1915 (Address) Dowland Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
if not at place of death?

Former or  
usual residence.

<sup>19</sup> PLACE OF BURIAL OR REMOVAL

Wesley Chapel DATE OF BURIAL Nov. 2, 1915

<sup>20</sup> UNDERTAKER

D B Bolden ADDRESS Oakland Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

oma, *Sarcoma*, etc, of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachoma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED	NOV 5 1915
BUREAU, V.S.	

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**1 PLACE OF DEATH**  
County Garrett

17649 (S)

**STATE OF MARYLAND  
CERTIFICATE OF DEATH**

Registration Dist. No. 171

Village or City Bittinger (No.)

St.: \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** Infant, of Albert Brememan

## PERSONAL AND STATISTICAL PARTICULARS

**3 SEX** Female **4 COLOR OR RACE** White **5 SINGLE,  
MARRIED,  
WIDOWED,  
DIVORCED** Single  
(Write the words)

**6 DATE OF BIRTH**  
Oct 25 1915  
(Month) (Day) (Year)

**7 AGE**  
..... yrs. .... mos. .... ds. If LESS than  
t day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

**8 OCCUPATION**  
(a) Trade, profession, or  
particular kind of work  
.....  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)  
.....

**9 BIRTHPLACE**  
(State or country) Md.

**10 NAME OF FATHER** Albert C. Brememan

**11 BIRTHPLACE OF FATHER**  
(State or country) Md.

**12 MAIDEN NAME OF MOTHER** Maudie Linden

**13 BIRTHPLACE OF MOTHER**  
(State or country) Pa

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Albert Brememan

(Address) Bittinger Md.

Filed 191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** \_\_\_\_\_, 191  
(Month) (Day) (Year)

**17 I HEREBY CERTIFY**, That I attended deceased from  
\_\_\_\_\_ to \_\_\_\_\_, 191\_\_\_\_, 191\_\_\_\_,

that I last saw h. alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Still born. Probably dead  
8 or 10 days before delivery.

(Duration) \_\_\_\_\_ yrs. .... mos. .... ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. .... mos. .... ds.

(Signed) R.C. Bowes, M. D.

Oct 25, 1915 (Address) Granville, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place \_\_\_\_\_ yrs. .... mos. .... ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. .... mos. .... ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence.

**19 PLACE OF BURIAL OR REMOVAL**

Bittinger, Md. DATE OF BURIAL  
Oct 25, 1915

**20 UNDERTAKER**

R.C. Buckel ADDRESS  
Bittinger, Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsinus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED	NOV 6 1915
BUREAU, V.S.	

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		STATE OF MARYLAND CERTIFICATE OF DEATH		
County	Garrison	17650	St.;	Ward) 168
Village or City	Fingell	(No.)	[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME Clara Colon				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX Female	4 COLOR OR RACE white	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widow	midaw	
6 DATE OF BIRTH June 22		(Month)	(Day)	(Year) 1862
7 AGE 52	8 yrs. 3 mos. 11 ds.	If LESS than 1 day, hrs. OR min. ?		
9 OCCUPATION House Keeper				
(a) Trade, profession, or particular kind of work				
(b) General nature of industry, business, or establishment in which employed (or employer) House work				
10 BIRTHPLACE (State or country) Md				
11 NAME OF FATHER Leo McKinzie				
12 BIRTHPLACE OF FATHER (State or country) Md				
13 MAIDEN NAME OF MOTHER Annie Gashly				
14 PARENTS (Address) Pa				
15 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Lloyd Brown				
(Address) Fingell Md				
16 Filed Nov. 3, 1915 Thomas J. Brown				
REGISTRAR				
17 MEDICAL CERTIFICATE OF DEATH				
18 DATE OF DEATH Oct 10, 1915, (Month) (Day) (Year)				
19 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1915, to Oct 10, 1915, that I last saw her alive on Oct 9, 1915, and that death occurred on the date stated above, at 8:00 p.m.				
The CAUSE OF DEATH* was as follows: Apoplexy				
(Duration) yrs. mos. 10. ds.				
Contributory Secondary				
20 (Duration) yrs. mos. ds.				
(Signed) H. L. Baker, M. D.				
(Address) 191, 108 Lake St., Md.				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
21 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)				
At place of death yrs. mos. ds. In the State yrs. mos. ds.				
Where was disease contracted, if not at place of death?				
Former or usual residence				
22 PLACE OF BURIAL OR REMOVAL Greenville, Pa. DATE OF BURIAL 10/13, 1915				
23 UNDERTAKER J. J. Dusost ADDRESS Fingell				

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

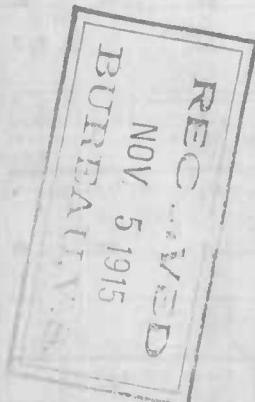
## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Miasma," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

**1 PLACE OF DEATH**  
County *Gardett*

17651

(18)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. *167*Village or City *Kemptown* (No.)

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** *Muir Domani*

## PERSONAL AND STATISTICAL PARTICULARS

<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word)
<i>m.</i>	<i>w.</i>	<i>Single</i>

**6 DATE OF BIRTH**

*Sep. 7, 1894*  
(Month) (Day) (Year)

<b>7 AGE</b>	if LESS than 1 day, hrs. OR min. ?
<i>21 yrs. 1 mos. 5 ds.</i>	

**8 OCCUPATION**

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)

**9 BIRTHPLACE**  
(State or country)*Muir Cool.**Russia.***PARENTS****10 NAME OF FATHER***Jam Domani.***11 BIRTHPLACE OF FATHER**  
(State or country)*Russia.***12 MAIDEN NAME OF MOTHER***Unknown.***13 BIRTHPLACE OF MOTHER**  
(State or country)*Unknown.***14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) *George St. George*  
(Address) *Kemptown*

**15**

Filed *October 14, 1915*—*J. W. Athernally*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH**

*Oct. 14, 1915*  
(Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased from**

....., 191..., to ..... 191...

that I last saw him alive on ..... 191...

and that death occurred on the date stated above at. 5 A.m.

The CAUSE OF DEATH\* was as follows:

*Came in contact with electric wire while putting car on track, which caused his death. Accident.*

(Duration) yrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.  
(Signed) *F. H. Pringle*, M. D.

, 191.... (Address) *Kemptown W. Va.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or  
present residence

**19 PLACE OF BURIAL OR REMOVAL***Thomas W. Va.***20 UNDERTAKER**

*J. H. Duncan* ADDRESS *Davis W. Va.*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

### American Public Health Association.

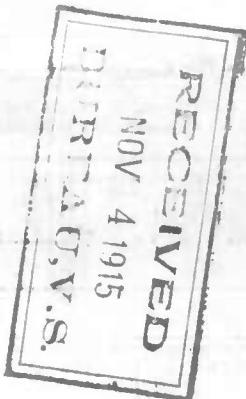
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a). *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma

*Sarcoma*, etc., of (name origin; "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chorio-  
villar heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 d.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ast-  
hnia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras-  
mus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæ-  
mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state ~~cause~~ of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomencla-  
ture of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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**1 PLACE OF DEATH**  
County \_\_\_\_\_  
*Towson*

17664

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 166

Village or City *Bayard Wh. Rd.* (No.)

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME** *Anna Jane Ewart*

## PERSONAL AND STATISTICAL PARTICULARS

<b>3 SEX</b> <i>Female</i>	<b>4 COLOR OR RACE</b> <i>White</i>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word) <i>Marrried</i>
-------------------------------	--	---

<b>6 DATE OF BIRTH</b>	, 1850
	(Month) (Day) (Year)

<b>7 AGE</b> 65 yrs.	If LESS than 1 day, .... hrs. OR min. ? mos. ds.
-------------------------	---

<b>8 OCCUPATION</b>	<i>House wife</i>
(a) Trade, profession, or particular kind of work.	
(b) General nature of industry, business, or establishment in which employed (or employer)	

<b>9 BIRTHPLACE</b> (State or country)	<i>England</i>
---	----------------

<b>10 NAME OF FATHER</b>	<i>Benjot</i>
--------------------------	---------------

<b>11 BIRTHPLACE OF FATHER</b> (State or country)	<i>England</i>
--	----------------

<b>12 MAIDEN NAME OF MOTHER</b>	<i>Asserence</i>
---------------------------------	------------------

<b>13 BIRTHPLACE OF MOTHER</b> (State or country)	<i>England</i>
--	----------------

<b>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE</b>	
(Informant)	<i>Thomas Ewart</i>

(Address)	<i>England Wm</i>
-----------	-------------------

15	Oct. 8th, 1915
Filled.	M. White
	S. REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** Oct 7, 1915 (Month) (Day) (Year)

**17** I HEREBY CERTIFY, That I attended deceased from Oct 3, 1915, to Oct 7, 1915, that I last saw her alive on Oct 3, 1915,

and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH\* was as follows:

*Heart trouble*  
*Weakness*  
*of lungs*

(Duration) yrs. 10 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.  
(Signed) *M. L. Barr Draper* M. D.

Oct 8, 1915 (Address) *Oxford Md*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death yrs. mos. ds. To the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

**19 PLACE OF BURIAL OR REMOVAL** *Chestnut Cemetery* **DATE OF BURIAL** Oct 9, 1915

**20 UNDERTAKER** *Scott Thompson* **ADDRESS** *Kingsville*

# REVISED UNITED STATES STANDARD

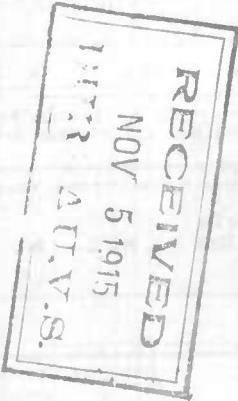
## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Thyroid fever* (never report "Thyroid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc.. *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic trilobular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mesles* (disease causing death), **29 d.**; *Bronchopneumonia* (secondary), **10 d.** Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County Garrett

17652

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 167Village or City Bayard, Wyo.

(No.)

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lyla Sylvia Thresa Everts

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)Single

6 DATE OF BIRTH

Feb. 11, 1902  
(Month) (Day) (Year)

7 AGE

13 yrs. 8 mos. 13 ds.If LESS than  
1 day... hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of workNone(b) General nature of industry  
business, or establishment in  
which employed (or employer)None

9 BIRTHPLACE

(State or country)

Ind

## PARENTS

10 NAME OF  
FATHERFreeman Everts11 BIRTHPLACE  
OF FATHER  
(State or country)Ind12 MAIDEN NAME  
OF MOTHERMinnie Klymiller13 BIRTHPLACE  
OF MOTHER  
(State or country)Ind

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. G. Dinkins, M.D.(Address) Lomania, Wyo.

15

Filed Oct 26<sup>th</sup>, 1915 I. W. Abernathy

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 24, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Oct. 23rd, 1915, to Oct. 24th, 1915,  
that I last saw her alive on Oct. 23rd, 1915,  
and that death occurred on the date stated above, at 39. m.

The CAUSE OF DEATH \* was as follows:

PeritonitisSix weeks (Duration) yrs. mos. ds.Contributory  
Secondary(Signed) W. G. Dinkins (Duration) yrs. mos. ds.  
Oct 24, 1915 (Address) Lomania, Wyo.\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL,  
SUICIDAL OR HOMICIDAL18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place  
of death yrs. mos. ds. In the  
Where was disease contracted,  
if not at place of death? State, yrs. mos. ds.Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Abernathy.

## DATE OF BURIAL

Oct 26, 1915

## 20 UNDERTAKER

I. W. Abernathy ADDRESS Eggar, Wyo.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc. *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

NOV 4 1915

BUREAU, U.S.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH County <u>Garett</u>		17653	STATE OF MARYLAND CERTIFICATE OF DEATH
Village or City <u>Kittymill</u> (No.)		151	Registration Dist. No. <u>12</u>
2 FULL NAME <u>Holmes. Hauness</u>		St.; Ward)	[If death occurred in a hospital or institution, give its NAME instead of street and number.]
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	16 DATE OF DEATH <u>Oct. 9</u> (Month) <u>1915</u> (Year)
6 DATE OF BIRTH <u>July 29</u> (Month) <u>1895</u> (Year)		If LESS than 1 day, hrs. OR min.	17 I HEREBY CERTIFY, That I attended deceased from <u>Oct. 7</u> , 1915, to <u>Oct. 8</u> , 1915, that I last saw him alive on <u>Oct. 8</u> , 1915, and that death occurred on the date stated above, at 2 P.M.
7 AGE <u>2 yrs. 2 mos. 2 ds.</u>			The CAUSE OF DEATH * was as follows: <u>Malaria</u>
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Kittymill</u>			
10 NAME OF FATHER <u>Ernest Garett</u>		Con contributory Secondary	
11 BIRTHPLACE OF FATHER (State or country) <u>West Virginia</u>		(Duration) yrs. mos. ds.	
12 MAIDEN NAME OF MOTHER <u>Maisie Holmes</u>		(Signed) <u>J. L. Sheppen</u> (Address) <u>Kittymill, Md.</u> M. O.	
13 BIRTHPLACE OF MOTHER (State or country) <u>West Virginia</u>		* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Ernest Garett</u>			
(Address) <u>Kittymill</u>		15 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place _____ of death _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____	
16 Filed <u>Oct. 10, 1915</u>		17 PLACE OF BURIAL OR REMOVAL <u>Hammel</u> DATE OF BURIAL <u>Oct. 10, 1915</u>	
REGISTRAR		18 UNDERTAKER <u>Barrett &amp; Co</u> ADDRESS	

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dry laborer*, *Farm laborer*, *Laborer*—*Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara mus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *lethargus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

NOV 3 1915

BUREAU OF THE CENSUS

## MARGIN RESERVED FOR BINDING

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Garrett 17654Village or City Near Henry W. Va

## 2 FULL NAME

Katy E. Alderman

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White American

5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

Single

## 6 DATE OF BIRTH

Mar 19, 1904  
(Month) (Day) (Year)

## 7 AGE

10 yrs. 6 mos. 19 ds.  
If LESS than  
1 day hrs.  
OR min.?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work(b) General nature of industry  
business, or establishment in  
which employed (or employer)

School

## 9 BIRTHPLACE

(State or country)

Garrett Co. Near  
Henry W. Va

## 10 NAME OF FATHER

J. H. H. Alderman

11 BIRTHPLACE OF FATHER  
(State or country)

Garrett Co. Md.

12 MAIDEN NAME OF MOTHER

Lydia R. Evans

13 BIRTHPLACE OF MOTHER  
(State, or country)

Preston Co. W. Va

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(informant)

M. S. Arnold

(Address)

Dobbin W. Va

## 15

Filed Oct. 3<sup>rd</sup>

1915

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 166

St.; Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

## 18 DATE OF DEATH

Oct. 1, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191 , to , 191 ,

that I last saw h alive on , 191 ,

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH was as follows:

Drowned in river  
Death was accidental  
child fell from foot  
log while crossing river  
(Duration) yrs. mos. ds.Contributory  
Secondary(Signed) M. R. Davis (Duration) yrs. mos. ds.  
Oct. 3, 1915 (Address) Henry W. Va.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

## 19 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

20 PLACE OF BURIAL OR REMOVAL Garrett Co. W. Va. DATE OF BURIAL Oct. 4, 1915

20 UNDERTAKER M. S. Arnold act ADDRESS Dobbin W. Va.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Deakr," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic natural heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchomeningitis* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

NOV 4 1915

BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH County.....		17655
Village or City.....		(No.)
2 FULL NAME..... Edd F Harvey		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single
6 DATE OF BIRTH Oct 23 (Month) (Day) 1915 (Year)		
7 AGE yrs. — mos. — ds. — yrs. — mos. — ds.		
If LESS than 1 day, 3 hrs. OR min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work Hiker		
(b) General nature of industry business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) Kitzmiller md		
10 NAME OF FATHER Edd F Harvey		
11 BIRTHPLACE OF FATHER (State or country) Wilson		
12 MAIDEN NAME OF MOTHER Ina May Davis		
13 BIRTHPLACE OF MOTHER (State or country) Elk Garden		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Edd F Harvey		
(Address) Kitzmiller. Md		
15 Filed Oct 24, 1915 A G Barreick		

151

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 172

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

St.; Ward)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
Oct 23<sup>rd</sup>  
(Month) , 1915 (Day), 1915 (Year)17 I HEREBY CERTIFY, That I attended deceased from  
Oct 23<sup>rd</sup>, 1915, to Oct 23<sup>rd</sup>, 1915,that I last saw him alive on Oct 23<sup>rd</sup>, 1915,  
and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Lack of vitality from  
pneumonia badly

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) G. L. Copeland, M. D.

(Address) Kitzmiller. Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,  
SUICIDAL or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)At place yrs. mos. ds. In the  
State, yrs. mos. ds.Where was disease contracted,  
If not at place of death?Former or  
usual residence19 PLACE OF BURIAL OR REMOVAL  
HomemillDATE OF BURIAL  
Oct 24, 191520 UNDERTAKER  
Barreick & Co.

ADDRESS

Md.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

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RECEIVED	NOV 3 1915	BUREAU, V.S.
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## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Garrett

17656

Village or City Maysville (No. 7)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 172

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME (Infant) Irvin

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
---------------------	------------------------------	---

6 DATE OF BIRTH

Oct 10, 1915

(Month) (Day) (Year)

7 AGE

1 yrs. 0 mos. 0 ds.

IT LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)Maysville Md

PARENTS

10 NAME OF FATHER

George Irvin11 BIRTHPLACE OF FATHER  
(State or country)Garrett Co W.Va

12 MAIDEN NAME OF MOTHER

Virginia McRobie13 BIRTHPLACE OF MOTHER  
(State or country)Mineral Co W.Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Irvin

(Address)

Chapleee W.Va

15

Filed Oct 11, 1915by W. H. Parrot

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct11, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191

, 191

that I last saw him alive on Oct 11, 1915

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Want Irvin only 1 day oldContributory Want Irvin  
Secondary

(Duration) yrs. mos. ds.

(Signed) J. P. Blaupanel (Address) Maryville Md  
M. O. Oct 12, 1915

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. mos. ds.  
of death \_\_\_\_\_ yrs. mos. ds.

In the State, \_\_\_\_\_ yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wilson MdOct 12, 1915

20 UNDERTAKER

ADDRESS

George IrvinChapleee W.Va

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Con-genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara-mus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED	NOV 3 1915
BUREAU, U.S.	

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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**1 PLACE OF DEATH**  
County Garrett

17657

**STATE OF MARYLAND  
CERTIFICATE OF DEATH**

Registration Dist. No. 162

St.: \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Grantville (No. \_\_\_\_\_)

**2 FULL NAME**

Baker Johnson

## PERSONAL AND STATISTICAL PARTICULARS

<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word)
<u>Male</u>	<u>White</u>	<u>Married</u>

**6 DATE OF BIRTH**

Sept 26th, 1850  
(Month) (Day) (Year)

**7 AGE**

65 yrs 7 mos 17 ds. If LESS than  
1 day.....hrs.  
OR.....min. ?

**8 OCCUPATION**

(a) Trade, profession, or  
particular kind of work Stone mason  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

**9 BIRTHPLACE**  
(State or country)

**10 NAME OF  
FATHER**

Thomas Johnson

**11 BIRTHPLACE  
OF FATHER**  
(State or country)

**12 MAIDEN NAME  
OF MOTHER**

Matilda Fuller

**13 BIRTHPLACE  
OF MOTHER**  
(State or country)

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mrs. Baker Johnson

(Address) Grantville, Md.

**15**

Filed 09/16/1915 by George Baker

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH**

Oct 13th, 1915  
(Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased from**

Aug. 8th, 1915, to Oct 13th, 1915,

that I last saw him alive on Oct 13th, 1915,

and that death occurred on the date stated above, at 12:00 p.m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Colon

(Duration) yrs. 6 mos. 0 ds.

Contributory  
Secondary

(Duration) yrs. 0 mos. 0 ds.

(Signed) P. C. Bowen, M. D.

Oct 16th, 1915 (Address) Grantville Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death yrs. 0 mos. 0 ds. In the State yrs. 0 mos. 0 ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence.

**19 PLACE OF BURIAL OR REMOVAL**

Grantville Md.

**DATE OF BURIAL**

Oct 16, 1915

**20 UNDERTAKER**

J.W. Winterberg Grantville Md.

ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired* 6 yrs.) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Tuerperal septicemias*," "*Tuerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

NOV 3 1915

BUREAU, U.S.A.

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Garret

17658

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 172Village or City Oncorill (No. Robert)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE,  
MARRIED,  
WIDOWED  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH Oct15, 1915  
(Month) (Day) (Year)

7 AGE

yrs. .... mos.  ds. If LESS than  
1 day  $3\frac{1}{2}$  hrs.  
OR  $\frac{1}{2}$  min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country) Md.

## PARENTS

10 NAME OF FATHER W.E. Johnson11 BIRTHPLACE OF FATHER  
(State or country) Territory12 MAIDEN NAME OF MOTHER Mary Meete13 BIRTHPLACE OF MOTHER  
(State or country) West Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W.E. Johnson(Address) Sheppie WVA

15

Filed Oct 14, 1915 A.C.B.

N.D.R.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 13  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
191 ..., to 191 ...that I last saw him alive on Oct. 13, 1915,  
and that death occurred on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH \* was as follows:

ConvulsionsContributory Delayed labor  
Secondary(Duration) yrs. mos. ds.  
(Signed) J.D. Sheppie (Address) Kittymiller Rd. M.O.

\* State the DISEASE CAUSING DEATH, if in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the  
of death Where disease contracted, State, yrs. mos. de.Where disease contracted,  
If not at place of death?Former or  
usual residence19 PLACE OF BURIAL OR REMOVAL WilsonDATE OF BURIAL Oct 14, 1915

20 UNDERTAKER

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

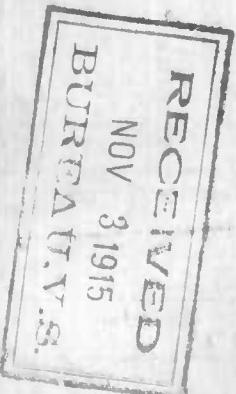
[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer in coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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**1 PLACE OF DEATH**  
County *Jarrett*

Village or City *Pipeland* (No.)

17659  
61

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. *166*

St: \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**2 FULL NAME***Cyra Sutherland Jordan*

## PERSONAL AND STATISTICAL PARTICULARS

<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WOOED, OR DIVORCED</b> (Write the word)
<i>Female</i>	<i>White</i>	<i>Married</i>

<b>6 DATE OF BIRTH</b>	<i>Aug 16</i>	<i>, 1878.</i>
	<i>(Month)</i>	<i>(Day)</i>
		<i>(Year)</i>

<b>7 AGE</b>	<i>37 yrs.</i>	<i>1 mos.</i>	<i>20 ds.</i>	<i>If LESS than 1 day.....hrs. OR.....min.?</i>
--------------	----------------	---------------	---------------	---

<b>8 OCCUPATION</b>	<i>H. St.</i>
(a) Trade, profession, or particular kind of work	
(b) General nature of industry, business, or establishment in which employed (or employer)	

<b>9 BIRTHPLACE</b> (State or country)	<i>Md.</i>
---	------------

<b>10 NAME OF FATHER</b>	<i>Cyrus S. Foster</i>
--------------------------	------------------------

<b>11 BIRTHPLACE OF FATHER</b> (State or country)	<i>New York</i>
--	-----------------

<b>12 MAIDEN NAME OF MOTHER</b>	<i>Sarah Jane Ennis</i>
---------------------------------	-------------------------

<b>13 BIRTHPLACE OF MOTHER</b> (State or country)	<i>Md.</i>
--	------------

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) *J.W. Foster*  
(Address) *Oakland, Md*

15 Filed *Oct. 9th, 1915* *M. L. White*  
*D. L. REGISTRAR*

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** *Oct. 8*, 1915  
(Month) (Day) (Year)

**17** I HEREBY CERTIFY, That I attended deceased from *July 1914*, to *Oct. 8*, 1915, that I last saw her alive on *Sept. 20th*, 1915, and that death occurred on the date stated above, at *106*. m. The CAUSE OF DEATH\* was as follows:

*Gent Paresis*  
*(Duration) 7 yrs. 0 mos. 0 ds.*

Contributory  
(Secondary)

*(Duration) 7 yrs. 0 mos. 0 ds.*  
(Signed) *J. W. Foster*, M. D.  
*Oct. 8, 1915* (Address) *Oakland, Md*

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place \_\_\_\_\_ In the  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

**19 PLACE OF BURIAL OR REMOVAL** *Paradise* **DATE OF BURIAL** *Oct. 10, 1915*

**20 UNDERTAKER** *D. B. Golden* **ADDRESS** *Oakland*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

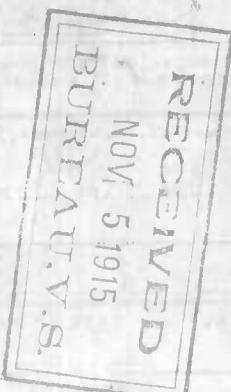
### Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc.. *Carcin-*

**oma**, **Sarcoma**, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), **29 d.**; *Bronchopneumonia* (secondary), **10 d.** Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trismia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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**PLACE OF DEATH**  
County Gaines

17660

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 166Village or City Oakland (No.)

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

**FULL NAME** Ayerslie Morella

PERSONAL AND STATISTICAL PARTICULARS			
<b>SEX</b>	<b>COLOR OR RACE</b>	<b>SINGLE, MARRIED, WIDOWED, OR DIVORCED</b> (Write the word)	
<u>Male</u>	<u>White</u>	<u>Single</u>	

**DATE OF BIRTH**  
December, 1,  
(Month) (Day) (Year)

**AGE**  
34 yrs. — mos. — ds.  
It LESS than  
1 day... hrs.  
OR min.?

**OCCUPATION**  
(a) Trade, profession, or  
particular kind of work  
Garden Stae Road  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)  
Stae Road

**BIRTHPLACE**  
(State or country)  
Ialey

**PARENTS**  
**10 NAME OF FATHER**  
Jacques Morella

**11 BIRTHPLACE OF FATHER**  
(State or country)  
Ialey

**12 MAIDEN NAME OF MOTHER**  
A. Morris

**13 BIRTHPLACE OF MOTHER**  
(State or country)  
Ialey

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
(Informant) Male Morella  
(Address) Oakland Md

**15**  
Filed Oct. 8th, 1915 M. White  
L. H. REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** Oct 1, 1915  
(Month) (Day) (Year)

**17** I HEREBY CERTIFY, That I attended deceased from  
—, 191— to —, 191—

that I last saw h. alive on —, 191—

and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH\* was as follows:

Agout Buttekey, Drawnred  
(Supposedly was lung Cancer)  
(Duration) Quinquevener  
Jrs. mos. ds.

Contributory  
(Secondary)

(Duration) yrs. mos. ds.  
(Signed) R. L. Broadwater, M. D.  
Oct 8, 1915 (Address) Oakland Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

**19 PLACE OF BURIAL OR REMOVAL** Oakland Md **DATE OF BURIAL** Oct. 8th, 1915

**20 UNDERTAKER** D. E. Baldwin **ADDRESS** Oakland

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonymy is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc.. *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), **29 ds.** *Bronchopneumonia* (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "As thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Trismia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Postpartal septicemia," "Postpartal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver wound of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**RECEIVED**  
NOV 5 1915  
BUREAU U.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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\* PLACE OF DEATH  
Garces

County.....

17661

176

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registered No. 166

St. .... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City..... Osseland (No.)

## \* FULL NAME

Charles Perry Robey

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
Male	White	Single, <i>single</i> (Write the word)

6 DATE OF BIRTH	Month	Day	Year
	March	31	1897

7 AGE	IF LESS than 1 day, .... yrs. OR min. ?
17 yrs. 6 mos. 2 ds.	

8 OCCUPATION	Telegraph Lineman
(a) Trade, profession, or particular kind of work	
(b) General nature of industry, business, or establishment in which employed (or employer)	

9 BIRTHPLACE (State or country)	Wash
------------------------------------	------

10 NAME OF FATHER	Geo W. Robey
-------------------	--------------

11 BIRTHPLACE OF FATHER (State or country)	Wash
---	------

12 MAIDEN NAME OF MOTHER	Cora S. Linaburg
--------------------------	------------------

13 BIRTHPLACE OF MOTHER (State or country)	Wash
---	------

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE	True
--	------

(Informant)	Geo W. Robey
(Address)	Ocean Roads Wash

15	M. White
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Filed Oct. 4th, 1915	S. L. REGISTRAR
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## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 3, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1915, to Oct 3, 1915, that I last saw him alive on Oct 3, 1915,

and that death occurred on the date stated above, at 145 P. m. The CAUSE OF DEATH\* was as follows:

Geo. W. Robey Run over by Horse & wagon BDRR. TR Long cut

18 (Duration) yrs. mos. 112 ds.

Contributory (Secondary) Wash (Duration) yrs. mos. ds.

(Signed) N. L. Bradenwicks, M. D.

Oct 3, 1915 (Address) Osseland Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 1/2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence. Ocean Roads Wash

19 PLACE OF BURIAL OR REMOVAL

Dorothy Innelle Wh. Union, 1915

20 UNDERTAKER

D. E. Pendleton

DATE OF BURIAL

Osseland Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Houskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc. *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Cholangitis*; *Heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trismia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED  
NOV 5 1915  
BUREAU, U.S.A.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<sup>1</sup> PLACE OF DEATH  
County Garrison

17662

Village or City Accident Md (No. 105)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 164St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

<sup>2</sup> FULL NAME Claudine Shewell

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX <u>Female</u>	<sup>4</sup> COLOR OR RACE <u>White</u>	<sup>5</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)
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<sup>6</sup> DATE OF BIRTH <u>Mar. 23</u>	<u>(Month)</u>	<u>(Day)</u>	<u>, 1913</u> (Year)
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<sup>7</sup> AGE <u>2 yrs. 6 mos. 16 ds.</u>	If LESS than 1 day, ____ hrs. OR ____ min. ?
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<sup>8</sup> OCCUPATION (a) Trade, profession, or particular kind of work <u>Laundress</u>	<sup>9</sup> OCCUPATION (b) General nature of industry, business, or establishment in which employed (or employer) <u>Laundress</u>
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<sup>10</sup> NAME OF FATHER <u>Frederick Shewell</u>	<sup>11</sup> BIRTHPLACE OF FATHER <u>Cove Md</u>
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<sup>12</sup> MAIDEN NAME OF MOTHER <u>Clara Beckett</u>	<sup>13</sup> BIRTHPLACE OF MOTHER <u>Cove Md</u>
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<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>William Durst</u>	<sup>15</sup> (Address) <u>Accident Md</u>
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Filed Oct. 12, 1915 by J. G. Richter

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

<sup>18</sup> DATE OF DEATH Oct 9th, 1915  
(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from Oct 7th, 1915 to Oct 9th, 1915,  
that I last saw her alive on Oct 9th, 1915,  
and that death occurred on the date stated above, at 7:30 P.M.  
The CAUSE OF DEATH\* was as follows:

Cholera dysentery.

(Duration) 3 mos. 3 ds.  
Contributory Chronic diarrhea  
(Secondary)

(Duration) 2 yrs. 0 mos. 0 ds.  
(Signed) W. C. Weddow, M. D.  
Oct 10, 1915 (Address) Friendsville Md

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 2 yrs. 0 mos. 0 ds. to the State 2 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? at place of death

Former or usual residence usual

<sup>19</sup> PLACE OF BURIAL OR REMOVAL Cove church Md DATE OF BURIAL Oct 12, 1915

<sup>20</sup> UNDERTAKER S. Savage ADDRESS Friendsville Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the **DISEASE** causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma

Surcoma

etc. of

(name origin; "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Ex. example: *Moselles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ast-  
henia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mara-  
inus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicar-  
mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomencla-  
ture of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

May 2 1915

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Garrett

17663

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 171Village or City Bittinger (No.)

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant of Adam Schneider

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
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6 DATE OF BIRTH	<u>Oct. 23d</u> , <u>1915</u>
	(Month) (Day) (Year)

7 AGE	If LESS than 1 day.....hrs. yrs. mos. ds. OR min. ?		
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8 OCCUPATION	(a) Trade, profession, or particular kind of work.  (b) General nature of industry, business, or establishment in which employed (or employer)		
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9 BIRTHPLACE (State or country)	<u>Md.</u>		
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10 NAME OF FATHER	<u>Adam Schneider</u>		
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11 BIRTHPLACE OF FATHER (State or country)	<u>Md.</u>		
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12 MAIDEN NAME OF MOTHER	<u>Ada Fagenbauer</u>		
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13 BIRTHPLACE OF MOTHER (State or country)	<u>Md.</u>		
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14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
--

(Informant) Mrs. Adam Schneider

(Address) Bittinger Md.

15 Filed 191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 25d, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Oct. 25d, 1915, to Oct. 25d, 1915.

that I last saw h. alive on Oct. 25d, 1915.

and that death occurred on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH\* was as follows:

Still born. Probably  
dead 8 to 10 days before  
delivery

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) P.C. Bowser, M. D.

Oct. 25d, 1915 (Address) Grantville Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ In the  
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,  
if not at place of death? \_\_\_\_\_

Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bittinger DATE OF BURIAL Oct. 24, 1915

20 UNDERTAKER C.C. Buschel ADDRESS Bittinger

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anesthesia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Traëmia," "Weakness," which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensus, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

